

## New development Spin-outs and social enterprise

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## **New development: Spin outs and social enterprise: the Right to Request programme in the English NHS**

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### **Abstract**

The Right to Request policy encouraged and supported NHS community health staff in England to 'spin out' services into social enterprises. This article considers the processes and outputs of the initiative and reflects on the likelihood of positive outcomes for patients being achieved. It highlights lessons for future programmes seeking to transfer services out of public ownership.

### **The Right to Request Scheme**

Launched as part of the NHS review led by Lord Darzi (DH 2008a), the Right to Request scheme enabled NHS staff providing community healthcare services in England to 'spin out' into social enterprises – 'business[es] with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners' (DTI 2002). Whilst precise objectives of the policy were not defined, the Department of Health (DH) staff guide (DH 2008) outlined that beneficiaries would include - *staff* (by creating conditions where they can 'innovate and lead rather than being told what to do'), *patients* (through the new organisations having 'the independence, flexibility and responsiveness to innovate and improve services and outcomes'), *wider communities* ('new organisations would have profits to invest in the community'), *commissioners* (through enterprises developing 'services to address the wider determinants of health') and the *public-purse* as whole ('organisational efficiency would be achieved through less-bureaucratic processes and a more engaged staff-group).

The introduction of the RtR was a significant further step in stimulating a market approach within the English NHS system. Previous initiatives had increased patient choice over which provider could provide elective procedures ('Any Willing Provider'), introduced a 'tariff' based payment system ('Payment by Results'), brought in additional capacity from the private sector (Independent Sector Treatment Centres) and introduced a new organisational form that had greater independence from government (Foundation Trusts) (see Allen et al 2011). The RtR was a radical development in that it sought to transfer core NHS community health services out of public ownership. Whilst this had been achieved in relation to other public services such as social care and housing, and in NHS support services such as cleaning and catering, successive governments had been unable or unwilling to outsource clinical services on such a large scale.

A previous pilot scheme had sought to explore the development or expansion of social enterprises delivering health (and social care) services (Tribal 2009). This identified a number of barriers, including - the time that it takes for new social enterprises to be developed, the uncertainty caused by short term contracts, loss of the NHS 'brand', and the perception by staff that they will lose their favourable terms and conditions (in particular their final salary pension schemes). RtR introduced specific measures to address these issues, for

instance through providing a guaranteed contract for between 3 and 5 years and the opportunity for transferred staff to maintain their pensions. To overcome the expected resistance from senior leaders there was a requirement that PCT Boards had to consider an expression of interest from staff in 'spinning out'. Significant external financial support was provided by central government through the Social Enterprise Investment Fund and this provided grants and loans to support the development of business cases (for instance in undertaking consultations, providing backfill for key staff and buying in external support) and to support the actual launch of the business.

### ***What have been the outputs associated with RtR?***

When the scheme was launched in 2008, the 152 PCTs in England employed approximately 200,000 staff within £10 billion worth of services that were eligible to apply for RtR (DH 2010). In November 2010 the Department of Health estimated that out of these services, 60 social enterprises would be launched. These were announced in three waves (see diagram 1) which included only those social enterprise proposals that received approval by the PCT Board following an initial expression of interest. Research within one local area (Miller and Millar 2011) identified that there were a number of proposals that did not proceed to the expression of interest stage, were not approved by the Board or which subsequently 'died' following the initial approval being granted. In early 2011 it was reported that ten of these 60 proposed social enterprises subsequently dropped out (NAO 2011), and at the time of writing (December 2011) only 38 of the 50 remaining projects had been successfully launched.

As a 'target' for the number of services to be 'spun out' was not made (in public at least), it is impossible to say if the realised level of outputs can be deemed as a success, but in November 2010 it was estimated by the Department of Health that 10% of the staff delivering NHS funded community services will be employed by social enterprises (DH, 2010) and that RtR organisations would deliver £0.9 billion of public services by the end of 2011 (NAO, 2011). Furthermore, no targets were proposed for the location of the RtR social enterprises, however we identified that they were not evenly spread, being largely concentrated in half of the English regions. Therefore, some areas will have a significant proportion of community health services delivered by social enterprises, whilst other regions will have none. For instance, in the South West up to 11 community services will be delivered by social enterprises, compared to none in the North East (see diagram 2).

### ***What will the outcomes be?***

Positive stories of the impact of externalising services into these enterprises are being promoted by the DH but in reality it is too early to assess if the broad outcomes will be achieved and sustained over a long-term basis. Furthermore, as highlighted by the National Audit Office(2011) no overall outcomes were set for the RtR programme and there are no plans at present to complete an evaluation of the long term impact on patient care and / or cost efficiency. Estimating the costs of the overall programme would require factoring in the salary costs of the staff leading the bid, the wider organisational and system resources connected with its development and assurance and arguably also the 'opportunity costs' from the services concerned being tied up in the process. These costs are not available, but the Social Enterprise Investment Fund invested in 51 Right to Request proposals at a total cost of £8,333,385 which gives an indication of the set up cost for these organisations.

There are essentially three main routes through which RtR could lead to improvements over the previous NHS ownership – firstly, the social enterprises will be able to better engage staff through developing new governance and ownership arrangements and this will lead to higher productivity, reduced sickness and a willingness to challenge poor practice and so improve quality. Secondly, the need to 'survive' in a competitive market place will result in the enterprises being swifter to respond to new opportunities and more able to convince staff that new working practices are required. Thirdly, even if the new organisations do not deliver

the suspected improvements, then the transfer out of the NHS means that the services can be tendered out more easily (including to private ownership).

There are examples of previous spin-outs in social care (such as Sandwell Community Caring Trust) and leisure services (such as Greenwich Leisure) which have been seen (by the organisations at least) as having transformed services. However there are also examples of when spin-outs have not survived (such as Secure healthcare which was set up in the pilot programme and collapsed in 2009), and the new social enterprises will have to win new (and protect current) business from FTs as well as private businesses. An evaluation of the Social Enterprise Investment Fund (Hall and Millar, 2011) indicated that around 10% of social enterprises in health and social care subsequently closed down after receiving SEIF investment due to a lack on further funding, thereby indicating their vulnerability. In relation to the creation of social enterprises leading to a more diverse market of providers, in areas in which all or most of community health services have been transferred to a single organisation, it is hard to see how this will lead to more options for patients. These large social enterprises could also potentially be interested in taking over smaller providers and so decrease competition.

### ***What can be learnt from the processes associated with RtR?***

Whilst the end outcomes are unclear, the process of RtR has successfully led to a sizeable proportion of a staff group with a strong loyalty to public sector delivery leading the 'spin out' to social enterprise. In reviewing the literature published to date on RtR and the experience of staff groups who set up (or attempted to set up) a social enterprise (Miller and Millar 2010; Hall et al 2011; Millar et al 2011, Addicot 2011; NAO 2011) five clear themes emerge:

#### ***1) Selling the benefits of Social Enterprise***

In RtR, the potential benefits of social enterprise for staff, patients and the community were emphasised by the government. For staff such benefits were experienced as the RtR was framed both in a 'positive' sense (i.e. social enterprises will enable you to deliver services more innovatively) and a 'negative' sense (i.e. social enterprises will enable you to escape the restrictions of the current bureaucratic system that you are currently locked in). The policy therefore sought to assure staff that in leaving the NHS they could 'keep their cake and eat it', as they would be able to keep the 'plusses' but lose the 'minuses' of the public sector.

#### ***2) Divide & Conquer***

If the Department of Health had attempted to 'force' staff groups to spin out into social enterprises it is likely that the policy would have met overwhelming resistance from unions and the general public. By giving local staff groups the power to choose to follow the externalisation route, the RtR arguably secured greater buy-in than if senior managers had made the same decision. It also diluted the impact of national union resistance as local stewards were often more amenable to the circumstances and concerns connected with the area in question (although there were examples of fledgling schemes being abandoned due to staff ballots which were influenced at least in part by union representations).

#### ***3) Provide nourishment***

Those who have gone through RtR are often clinicians and will generally have spent their careers within the public sector and so have no experience in running their own business. Investment therefore has to be made in supporting them to develop the business, management and financial skills needed to develop a business case and survive within a competitive market (also see Macmillan, 2010). Mentoring was also helpful as a means of support for the leaders of the new organisation and to provide examples of successful approaches

used in other organisations.

#### *4) Threaten with a stick*

In addition to possible positive benefits of RtR, staff were also 'warned' that the likely consequence of not spinning out was being transferred to another NHS organisation that they may not have seen as favourable to their service such as a large acute Trust or being put out to tender for private sector companies to bid. These changes would be led by the senior leadership team and RtR was the only means through which staff could have any control over their destiny (it should be noted that the majority of community health services have been transferred to other organisational forms within the NHS and the staff concerned may have felt this was the right option in their area).

#### *5) Get the locals chiefs on-board*

The regional variation in the take up of RtR reflects at least in part in the different response from individual PCT Boards and their local Strategic Health Authorities. Whilst each case clearly had to be considered on merit, there is no doubt that in some areas there was a reluctance or unwillingness to support social enterprise spin-outs from those 'at the top'. It is perhaps understandable why such Boards would be unwilling to select an option that could be more time-consuming and potentially vulnerable to organisational failure than taking the 'safe' option of transferring to another NHS body. Winning over these Boards and the individuals within them required a similar mixture of 'soft' and 'hard' incentives to that deployed to the staff groups and this is an aspect that the RtR programme could have improved upon.

## ***Conclusion***

The RtR scheme sought to spin-out public sector services as part of a broader reform programme to extend the market within English health care. It has been followed in England by a Mutuels Programme to support the development of 'public sector mutuels', the Right to Provide (which is similar to Right to Request but applies to social care staff employed by the Local Authority and health staff in Trusts that have not yet become FTs), and social work practice pilots in which local authority teams responsible for children and young people who are leaving care are seeking to spin out.

If all of these programmes are able to achieve or overtake the level of success of RtR in introducing greater diversity of provision, then there will be further significant externalisation of services traditionally provided by the public sector. The most important issue in relation to the overall success of such programmes is the extent to which these new arrangements are in fact able to combine the best of public sector values with the responsiveness and efficiency of private business, and this cannot be evaluated for some time to come. However, as a minimum, the RtR provides an example of a process through which governments can spin-out public sector services in the face of potential large scale opposition from unions and existing healthcare institutions and professionals.

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